QUESTIONS AND ANSWERS
From All-Plan Technical Workgroup Meeting
March 16, 2004

Questions from the All-Plan Technical Workgroup Meeting have been divided into the following general topics/categories for presentation. Subsequent questions submitted by Plan representatives and other clarifying information have been added to the categories.

- Moving to the ASC X12N 837 Format - Reasons for the new requirement
- DSHS/MAA to assist Plans with implementation and testing
- Date of Service vs. Process Date and Submission Time Periods
- Data Submission format clarifications
- Specific Data Issues

Moving to the ASC X12N 837 Format - Reasons for the new requirement:

1. ***Question****:* How do plans justify the cost associated with implementation of the new 837 format? What is the justification for spending money to convert when the current system is working and the new 837 format is not a federal requirement?
   Answer: DSHS/MAA's decision to change to the new ASC X12N 837 format was presented at the 3/16/04 meeting and is attached here for your information as *837_Format_ChangeReason.doc*. While encounter data submission is federally mandated, neither the current proprietary format nor the new ASC X12N 837 format are federal requirements. DSHS /MAA implemented the change for the reasons stated in the attachment, and require data that meets federal requirements. While initial conversion costs are recognized, efficiencies and streamlining introduced by the utilization of a single format for health care reporting are expected to be realized long into the future.

2. ***Question:*** Can MAA continue to accept the current proprietary format and convert it to an 837?
   Answer: No - The current proprietary format does not provide sufficient data for MAA to accept that format and perform the conversion to the ASC X12N 837 format.

DSHS/MAA to assist Plans with implementation and testing:

3. ***Question:*** How can DSHS/MAA assist Plans with the implementation of this change?
   Answer: MAA will be establishing a testing Help Desk with a testing coordinator for implementation of Encounter Data ASC X12N 837 format. The DSHS/MAA testing coordinator will perform user testing prior to July 1, 2004 (see schedule below) and will provide individual assistance as plans begin the testing process. In addition, the testing

coordinator will publish "testing tips" that will assist plans in the identification of items that may be of interest.

4. ***Question:*** What is the testing process? Is ACS ready to accept test claims now? Can plans send sample data to test?
   Answer: The testing timeline and process is as follows:
   - May, June 2004: DSHS testers will submit test records and establish testing process;
   - No earlier than July 1, 2004 – Plans may start submitting test files;
   - No later than October 1, 2004 – Plans must start submitting test files;
   - January 1, 2005 – Move to full production.

5. ***Question:*** Will plans be able to submit data in old format and new format for a while?
   Answer: Submission of old format and new format will be limited to the testing period. The expectation is that during the testing period, plans will work with DSHS/MAA to identify and correct data format and submission problems.
   - Beginning with the July 1, 2004 process date, MAA will accept Test Submissions in the **new ASC X12N 837 format**;
   - Production Submissions due July 01, 2004 for Q1 2004 and October 01, 2004 for Q2 2004 will be in the **current proprietary format**. Resubmissions (if needed) for these two quarters will also be in the **current proprietary format**;
   - Production Submissions beginning January 01, 2005 for Q3 2004 must be in the **new ASC X12N 837 format**.

Date of Service vs. Process Date and Submission Time Periods:

6. ***Question:*** Would MAA consider changing the implementation from July 1, 2004 Date of Service to July 1, 2004 Process Date?
   ***Answer*:** MAA is willing to change the requirement from July 1, 2004 Date of Service to July 1, 2004 plan Process Date. MAA will bear the responsibility for merging reporting requirement formats for a period of time.

7. ***Question:*** In what format will run-out be required (claims with a Date of Service prior to July 1, 2004 processed after July 1, 2004)?
   Answer: Run-out should be submitted in the new ASC X12N 837 format for all claims/encounters processed by the plan after July 1, 2004.

8. ***Question:*** Why July 1, 2004 for January 1, 2005 reporting?
   ***Answer*:** July 1, 2004 represents the beginning of State Fiscal Year 2005. Originally, DSHS selected January 2004 as an implementation date for the new requirements. A decision was made to provide plans additional time to complete programming necessary to move to the new format, and to coincide with the beginning of the State Fiscal Year. Many of the DSHS Encounter Data reports are on a fiscal year basis.

9. ***Question:*** If plans submit 2004Q3 in December rather than January, is the current proprietary format acceptable?
   Answer: No - The change to "process date" should clarify this question. Any claims/encounters processed by the plan after July 1, 2004 must be submitted in the new ASC X12N 837 format beginning January 1, 2005.

10. ***Question:*** Is MAA considering changing the quarterly submission requirement to monthly?
    Answer: The new ASC X12N 837 format and submission process allows plans to submit batch data anytime. By contract, plans must encounter data at least quarterly. Data will continue to be reviewed quarterly by MAA regardless of the frequency that plans choose to submit the data.

Data Submission format clarifications:

11. ***Question:*** Will pharmacy data need to be submitted separately with the new process?
    Answer: Yes – for a time being. Beginning with processing dates July 1, 2004 and after, professional and institutional encounters must be submitted in the new ASC X12N 837 format. Pharmacy claims/encounters (Encounter type "D") will continue to be submitted in the current proprietary format until the NCPDP 1.1 batch format is implemented by MAA.

12. ***Question:*** Will 837P and 837I need to be submitted separately?
    Answer: The 837P and 837I are separately submitted data structures, but do not require separately submitted transmissions. A data structure (or envelope) is made up of Header records, body records, and Trailer records. In order to differentiate the Functional Group Header information, such as GS01, GS02, etc., the 837P and 837I must be separated into separate envelopes. However, multiple envelopes may be in the same transmission.

Three Levels of Submission/Analysis:

A. Submissions through EDI Gateway (batch level):

13. ***Question:*** What is the initial batch submission process? What is accepted/rejected through the EDI Gateway, and what is the return notification?
    Answer: Initial batch submission of ASC X12N 837 encounters will be transmitted to the ACS EDI Clearinghouse for EDI verification and translation to the MMIS Interface Record Layout (IRL). A 997 transaction will be returned to the plans indicating acceptance (positive 997) or rejection (negative 997) of the batch.

14. ***Question:*** What HIPAA 837 fields are required to be accepted through the EDI gateway?
    Answer: Documentation of field requirements is contained in the ASC X12N Implementation Guides. See http://www.wpc-edi.com/Insurance_40.asp for Implementation Guide information. In addition, the Testing Help Desk will assist with answering any questions. The EDI gateway edits are mainly checking for structure and construction of records and fields. There will be certain fields that can be "gap" filled in order for the transactions to be accepted.

15. ***Question:*** How are files transferred?
Answer: The ASC X12N 837 Companion Guide (available at the address below) provides general information on data transmission and file transfer. http://www.acs-gcro.com/Medicaid Accounts/Washington State Medicaid/Companion Guides/WA_837_CG_1.05.pdf For plans that have a submitter number utilized for other EDI transactions, a separate number will not be needed. If a plan does not have a submitter number, they will need to contact EDI per the instructions contained in the Companion Guide,

16. ***Question:*** In what format will resubmissions be accepted?
***Answer*:** Resubmission will be accepted in the same format as the submission of the original encounter data report.
    - Between July 1, 2004 and January 1, 2005, production resubmissions will be in the **current proprietary format**;
    - Between July 1, 2004 and January 1, 2005, testing resubmissions will be in the **new ASC X12N 837 format**;
    - After January 1, 2005, production resubmissions will be in the **new ASC X12N 837 format**.

17. ***Question:*** What level of edit is applied by EDI-Gateway? What edits will ACS be using?
***Answer*:** The ACS EDI-Gateway reviews data for formatting errors. This includes missing data, or incorrect 8-fills, 9-fills, 0-fills, or hyphen-fills for required fields. Please see the ASC X12N 837 Companion Guide for more detailed description of the EDI edits applied. MAA expects that certain fields at this level must be "gap" filled to pass the edits.

B. After EDI Gateway – submission goes through MAA Edits for Encounter Data Processing (claim level):

18. ***Question:*** What HIPAA 837 fields are required to be accepted through the MAA edits for Encounter Data processing?
Answer: Documentation of *MAA Edits for Encounter Data Processing* is attached. The Testing Help Desk will be available to assist in answering any questions. As noted in the documentation, MAA Edits for Encounter Data Processing are primarily checking for further syntax and established content criteria.

19. ***Question:*** Once the batch transmission has been accepted, how will encounter errors be identified? Will MAA be attaching an ID number for each line?
Answer: The MMIS edit processor for Encounter Data will assign an Internal Control Number (ICN). Encounter ICNs will always begin with a "9" and will be returned to plans with the error information. This information (see Question 21 for additional details) will be returned to the plans ONLY for the encounter records that require correction.

20. ***Question:*** What will the cycle be for corrections? Can the plan have the option for re-submitting corrections on a monthly basis?

Answer: Corrections may be resubmitted at any time but resubmission of corrected records must not exceed 90 days per contract.

21. ***Question:*** What will the error report look like?
Answer: An electronic non-HIPAA Encounter Results Transaction (ERT) will be created and forwarded to the Managed Care Plan listing all encounters received and the reason for the "Rejected" encounters. The Encounter Results Transaction (ERT) will contain the following fields:
    - Patient Account Number (submitted) – 38 character field (for 837I this is where the plan should report their own internal control number for the claim/encounter)
    - Medical Record Number (submitted) – 30 character field (for 837P this is where the plan should report their own internal control number for the claim/encounter)
    - MMIS Internal Control Number (ICN) – 17 character field beginning with "9"
    - An array of error flags indicating the error and encounter record line number when appropriate – 6 digit field that repeats 100 times

    A sample Encounter Results Transaction (ERT) is attached for your reference as *Sample_ERT.doc*.

22. ***Question:*** Is the rejection and/or resubmission at the line level or claim level?
***Answer*:** Rejection and/or resubmission occurs at the claim level. The ERT error report will identify the claim and line number where an error is identified, but **the resubmission is expected to be a replacement of the entire claim**. This eliminates potential problems with the tracking of line additions, deletions, and line reordering issues.

23. ***Question:*** How will MAA know if it is a corrected line item? Will the plan be required to re-submit all records or just corrected records?
***Answer*:** Rejected Encounter records must be resubmitted after corrections are made. For ASC X12N 837 Encounter Records, the "Claim Frequency Type Code' of the corrected record should be "7" indicating Replacement and the "Claim Original Reference Number" should contain the MMIS ICN (beginning with "9") of the rejected record, as identified in the ERT. If an Encounter Record has been rejected more than once, the ICN of the most recent rejected Encounter Record must be used. Plans are required to resubmit only rejected/corrected records.

24. ***Question:*** What sanctions will be in place for the error rate?
Answer: Sanctions will be specified in the Healthy Options contract. Specific actions related to data submission errors will be addressed per contract specifications.

C. Quarterly Analysis by Encounter Data Unit (analysis level):

25. ***Question:*** What is the process for quarterly Encounter Data Unit (EDU) analysis?
Answer: Quarterly analyses will be completed by EDU. An EDU analysis/evaluation may result in a request that certain encounters submitted during a time period, including an entire quarter, be resubmitted, depending on the extent and severity of the problem. EDU will coordinate closely with Division of Program Support/Healthy Options Contract Managers to finalize analyses and with Plan technical representatives to correct identified errors.

26. ***Question:*** What is the list of edits?
Answer: Edits occur at three points in the encounter data submission process.
    - EDI (batch) edits
    - MAA Encounter Data Processing (claim) edits
    - MAA/EDU (analysis) edits

    A list of MAA Encounter Data Processing Edits is attached as *MAA Edits_ED Procssing.doc*

27. ***Question:*** Will "pendable" errors be used in calculation of risk adjustment? What encounters will be used for risk adjustment?
Answer: For purposes of this Question and Answer document, DSHS is defining "pendable" errors as those encounters that are rejected at the point of MAA Encounter Data Processing Edits, and returned to the plans via the ERT for correction. Thus the question becomes: will these rejected encounters be used for risk adjustment, whether or not corrected encounters have been resubmitted by the plans? Data quality decisions regarding the appropriateness of data for risk adjustment and other rate determinations will be made at a time needed for each of those processes during 2005 and thereafter. MAA cannot anticipate what our actuarial consultants may require regarding data quality for analyses to be conducted in the future. Therefore plans are urged to provide the best quality data possible and give due diligence to the encounter resubmission/correction process.

Specific Data Issues

28. ***Question:*** Will the NDC number be required on 837 professional encounters? What is the purpose for this requirement?
Answer: The NDC will not be required on the ASC X12N 837 professional encounters. The NDC requirement was initiated on Fee-For-Service claims to gather information for federal rebate. This does not apply to encounters, so the requirement has been dropped. **NOTE:** The NDC number is still required on all retail pharmacy encounters reported in the proprietary format.

29. ***Question:*** What are the requirements for Performing, Referring and Attending Providers? Are Medicaid provider numbers required in the performing, referring, attending numbers fields in order to pass the batch submission edits, MAA Encounter Data Processing edits?
Answer: DSHS will require the 7-digit Medicaid Provider ID to be submitted in the Performing, Referring and Attending Provider data fields. However, it is recognized that the provider networks of some plans include providers who have no Medicaid Provider ID. For those non-Medicaid providers, DSHS will assign a unique number to each plan that can be used to designate "Non-Medicaid-Participating provider".

    DSHS will be conducting analyses of current submissions and working with each of the Plans to establish an acceptable estimate of the percentage of providers who fall into the "Non-Medicaid-Participating provider" category. Once that percentage is established, analyses will be conducted to assure that Plan submissions using this number as the identifier of Performing, Referring and Attending Provider do not exceed that threshold.

MAA will modify these requirements in coordination with the implementation of the National Provider Identifier. Timelines for implementation have yet to be established.

30. ***Question:*** The current Provider Master File sent to Plans each month has changed and no longer contains begin and end dates. Can that be changed?
    Answer: The Provider Master File will be modified to include begin and end dates of Provider enrollment for ease of historical tracking and identification of "active" Medicaid Provider numbers.

31. ***Question:*** Can "required if known" be clarified? Could the designation be changed to "Optional" if that is the intent? Should plans re-submit "Required if known" if information is later found?
    Answer: The ASC X12N 837 crosswalk document will be changed to note fields as "Required" or "Optional".

32. ***Question:*** How will Baby on Mom's PIC be handled?
    Answer: The subscriber will always be the patient for encounter data reporting. MAA does not use the dependent Loop in the 837. The ASC X12N 837 crosswalk will be updated to reflect this.

33. ***Question:*** Will MAA accept "temp" codes prior to formal HCPCS issuance? How often are CPT/Standard codes updated?
    Answer: MAA will accept all standard HCPCS and CPT codes where applicable. Code sets are updated in the MMIS according to each standard code set schedule. When temporary codes are created, MAA policy and medical staff review and make decisions regarding the adoption of new temporary codes. If the decision is made to adopt, the temporary codes are loaded into the MMIS effective January 1 of each year.

34. ***Question:*** Is the provider crosswalk necessary?
    Answer: Since MAA will be requiring Medicaid Provider ID numbers for Performing, Attending and Referring providers or assigning codes for Non-Medicaid providers, there will no longer be a need for the provider crosswalk.